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ABSTRACT

Eight papers focus on sex education for deaf students. R. Davilla ("Sex Education from the Deaf Perspective") suggests that sex education is not the responsibility of any one group, but that special educators have a special responsibility in this area. D. Fitz-Gerald and M. Fitz-Gerald cite barriers facing deaf persons in receiving sex education and assert that "Deaf People Are Sexual, Too!" The Fitz-Geralds then consider (in "Behind the Times") the role of the parents and the residential school in providing sex education to deaf students. Among the "Sexual Implications of Deafness" considered in a fourth paper (D. Fitz-Gerald and M. Fitz-Gerald) are the impact of residential schools and the difficulties of understanding such abstract concepts as maleness and femaleness. D. Fitz-Gerlad, M. Fitz-Gerald, and C. Williams consider the status of teacher preparation in "Sex Educator: Who's Teaching the Teacher Sex Education?" They review a survey of teacher training programs that highlighted a need for more in-depth training. A sixth paper reviews results of a sex education survey of residential facilities for the deaf. The Fitz-Geralds summarize responses that indicated one out of three residential programs offered no sex education as a specific course, "Human Sexuality and the Handicapped Child," by D. Fitz-Gerald and M. Fitz-Gerald, traces normal sexual development and comments on the professional's role in fostering healthy sexuality for deaf persons. The final paper, "Parents: A Child's First Sex Educator," by M. Fitz-Gerald, emphasizes the parents' critical role. (CL)

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Sexuality and Deafness

May 1979

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FOREWORD

It is an interesting fact that those subjects which most affect our lives often receive the least attention in research and education. This is especially true of sex education for the hearing impaired.

Scientific knowledge on sexuality and the hearing impaired is a brand-new field. Although there is a multitude of ideas and opinions--often full of contradictory and confusing concepts -- on the subject, there is a distinct lack of adequate research and sound educational principles available. This is in pronounced contrast to the increased efforts being made in other academic areas such as reading and career education. This situation undoubtedly reflects the persistent belief that if you teach sex education, sexual promiscuity will result.

It should be obvious that there is, today, no scarcity of interest in sex nor in exploring the avenues of sexual experience. What is lacking is the opportunity to receive accurate information and an appropriate forum for integrating and assimilating this information into a system of personal values.

The primary focus of these papers is on information designed to increase the readers' awareness of the need for instruction in sexuality for hearing impaired individuals of all ages. Since parents, teachers, and administrators generally have lacked scientifically based education about sex, these papers should be useful to a broad range of readers.

We in the field of education of the hearing impaired must take the initiative in guaranteeing that hearing impaired children of all ages are provided with every possible opportunity to develop a healthy, positive, and responsible sexuality, a goal that can be reached by deaf and hearing individuals working together. After all, we are all sexual beings. My hope is that these papers will lead to expanded research and educational opportunities on a subject that has been ignored for far too long a time.

Robert R. Davila
Vice President
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SEX EDUCATION FROM THE DEAF PERSPECTIVE

Robert R. Davila

If there is general agreement that sex education of the general school population has been shamefully neglected, then neglect of the hearing-impaired and other handicapped children in this area has bordered on dereliction of duty on the part of educators and parents alike.

Traditionally, education of the hearing-impaired has been centered in residential schools. The primary purpose of residential school placement is not to isolate children from their families and communities, but rather to provide high-quality educational programming, not always possible in local school systems. Residential school placement requires that administrators accept responsibility for comprehensive programs of instruction and care that go far beyond the normal requirements of an ordinary public day school. Assuming responsibility for the educational, spiritual, social, and emotional development of young people in a surrogate manner is a tremendous responsibility. Schools are to be commended for trying to be all things to all children. I cannot say, however, that it has always been possible to fulfill this expectation.

I remember, when I was a young boy, one of the first sex education films to make a big impact on the general public was making its appearance around the country, a film called Mom and Dad. I recall being told

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by the dormitory supervisor in the residential school which I attended that under no circumstances would we be permitted to see the film! Needless to say, those few who defied that regulation and saw the film were reprimanded. So much for sex education in those days! We kids managed to pick up everything we needed to in the locker room anyway. Hasn't it always been this way? Unfortunately, yes!

I am happy to report that there has been some improvement over the years. Residential schools are not the monastic institutions that we have traditionally pictured them to be. Nowadays we need only to look to the various tracts that have come into print emphasizing the needs of the handicapped in the area of sexuality and sex education, to realize that the general public still needs much information and orientation to the special needs of the handicapped. But there is at last a realization that the handicapped are human, too, and that their desires, wants, and needs are no different from those of anyone else.

To my way of thinking, sex education is not the responsibility of any single group or agency, but rather is a community-wide responsibility. By this I mean that the home, the school, and the community all share in the responsibility for developing healthy, socially acceptable attitudes and codes of conduct in matters related to sexuality. The matter cannot be turned over to the parish priest or minister, nor can we expect that the classroom teacher, who may or may not be qualified to treat the subject adequately, will carry the entire responsibility. Needless to say, parents will not be much help if they themselves do not feel comfortable about the subject, or if they are lacking in the very knowledge they are trying to give their children. So what do we do? That is the problem.

Already we have a situation in which young people are bombarded daily through the mass media with messages that border on the ridiculous. Half-dressed, seductive-looking women, for example, advertise a product that often gets lost in the sexual implications of the message. Farrah Fawcett-Majors would have you think that by using a certain shaving cream, something more than shaving cream will pop out like a genie the next time you push the release button. Actually, in a commercial like that, the real message is SEX! The shaving cream is only incidental; the girl is the product.

When such great emphasis is placed on sex and physical attractiveness by the media, what is the effect on hearing-impaired youngsters who cannot hear the message but who see the alluring, suggestive, physical overtures in the message? The handicap of hearing impairment is one of the most severe of all handicaps because it strikes at a basic human function -- communication. Too often you have heard the statement that when you are out of communication, you are "out of it." Let us not underestimate this saying; it is very true. Hearing-impaired persons will, therefore, attach more meaning to that which is visual. Quite often a hearing-impaired youngster will make a literal interpretation of what he/she sees. Farrah Fawcett-Majors coming at you with that suggestive look wants only one thing -- that!! As for shaving cream, the deaf youngster never heard it.

The needs of the handicapped in the area of sexuality and sex education are similar to those of the general public, but they may need special materials in order to understand the message that is being communicated. What is needed in order to permit handicapped people to live full, rich, and rewarding lives is a concerted effort on the part of

publishers and curriculum designers to keep the handicapped in mind when materials on sex education are designed, developed, and published. Recent studies, for example, indicate that minority children identify with characters in the media who represent their own minority group. This "modeling" helps in the development of a positive self-image. The same is true for the handicapped.

We also need to provide media and materials that are largely self-explanatory and not too verbal for those who have a language deficiency. We need to stress the importance of including the handicapped in all programs dealing with human sexuality. Whenever such programs are being planned, we must be sure that consideration is given to the inclusion of special materials for the hearing-impaired. Even when it is not feasible or necessary to create special materials, modifications or adaptations of existing materials could be very useful; for example, records and large-type or Braille materials for the visually impaired; and visual, modified-language-content materials for the hearing-impaired.

I started off by saying that I do not think that sex education should be the responsibility of any one person or group. However, I do feel that the uniqueness of special education provides a mandate for educators to go far beyond the ordinary day-to-day responsibility of the public school in providing for the daily present and future needs of handicapped youngsters. Schools and programs for the hearing-impaired have been assuming such responsibilities for many years. I received all of my religious education in a publicly supported, nondenominational school for the deaf. I learned many things in school that would otherwise have been the responsibility of my parents.

A new law, the Education for All Handicapped Children Act of 1975 (P.L. 94-142), creates a viable means for educators of the handicapped to go beyond what they are now doing and to include a complete program of preparation for life for their charges. Sex education is one of the very important areas in which this preparation and development must take place. The time, therefore, is now, in the context of this new public mandate, to move boldy forward in meeting the needs of the handicapped.

Educators and parents must not pass up the present opportunity to bring pressure to bear on local, state, and federal agencies to develop good programs in sex education. Counseling programs must be made available through schools and rehabilitation agencies to assist the handicapped with sex-related problems and concerns. Perhaps never again will there be a time more opportune than the present to achieve these ends.

DEAF PEOPLE ARE SEXUAL,TOO!

Della Fitz-Gerald
Max Fitz-Gerald

What is deafness? It is far more than the inability to hear sound. Very few people realize that hearing impairment is the single most prevalent chronic physical disability in the United States today. More people are affected by a hearing difficulty than by visual impairment, heart disease, or any other chronic disability. In 1974, the National Census of the Deaf Population (N.C.D.P.) identified 13.4 million persons with a hearing impairment, of whom 1.8 million can be classified as deaf (Schein and Delk, 1974). (This population consists of those persons who could not hear and understand speech and who had lost, or never had, that ability prior to 19 years of age.)

You have probably seen a deaf person without being aware of it, since there are no distinguishing physical characteristics associated with this impairment. In fact, deafness has been called the "invisible" handicap. This lack of visibility is not always an advantage, for it tends to foster greater misunderstanding regarding the implications of hearing impairment. This lack of understanding was poignantly illustrated in a 1976 Gallup Poll of 1,548 persons, which revealed that only 1 percent of those questioned feared deafness, as compared with 21 percent who feared blindness. From time to time, we may even long not to be bothered by all the noise pollution that surrounds us. However, such

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a "luxury" would have far greater implications than one realizes. Just the simple act of exchanging verbal communication would be limited, if not precluded. The personal, educational, social, and vocational implications of deafness are multifarious, thus making the development of a healthy sexuality far more complex in children with hearing handicaps.

What is Deafness?

Profound deafness is represented at the extreme end of the hearing continuum, and can be classified as an impairment so profound as to require the individual to employ a visual means of communication. For the deaf, ordinary auditory feedback is not sufficient for speech to be understood, even when amplified by a hearing aid. In between those who are deaf and those who are hearing are the hard of hearing. "A hard of hearing person is one who, generally with the use of a hearing aid, has residual hearing sufficient to enable successful processing of linguistic information through audition" (Report of the Ad Hoc Committee to Define Deaf and Hard of Hearing, October, 1975).

Deafness can be divided into two categories: congenital deafness, meaning deafness which has been present from birth; and adventitious deafness, meaning that which began sometime following birth. The adventitiously deaf can be further divided into those who became deaf before the development of speech and language (the prelingually deaf). and those who became deaf following the acquisition of speech and language (postlingually deaf). Obviously, the severity of the implications of deafness are much greater for the congenitally and prelingually deaf. For them, the development of speech, language, and verbal abstractions is a continuous struggle. The hearing person, simply by

having ears that hear, is constantly and effortlessly bombarded with speech and language in all their nuances. It is this very bombardment that enables the hearing person to develop speech and language skills. With the tools of speech and language, we are better able to understand and manipulate our environment. Without those tools, the deaf individual is deprived of a vast amount of general and personal knowledge.

Understanding such abstract concepts as maleness, femaleness, parenting, relationships, and reproduction becomes secondary when one has to struggle with the basic labeling of one's body parts. For example, the average hearing child upon hearing a word several hundred times, usually can integrate that word into his/her vocabulary. The deaf child, because of the nature of the impairment, is denied this verbal repetition and ultimately the word itself. For the deaf child, the integration of just one word into the vocabulary requires that someone point out, show, demonstrate again and again what is being taught.

How Do Deaf People Communicate?

It is not surprising to find that the history of education of the deaf has focused primarily upon the development of speech and language. Unfortunately, the task has been further complicated by the controversy over teaching methodologies; that is, whether a child should be taught by the oral method (speech and speechreading) or the simultaneous method (speech, speechreading, and signs). The controversy is centuries old, and still continues, having spread from its origin in Europe to all parts of the world. Ancient philosophies once believed that speech proficiency was a measure of intelligence, and that speech was the only channel for communication with God. After all, God was not skilled in sign language,

and therefore the deaf had to learn to speak if their souls were to be saved. It was with this thought in mind that many of the first efforts were made to educate the deaf.

Sign language is the preferred mode of communication among most of the deaf (Kannapell, 1974). Most deaf persons today use some type of hand-signaling system in conjunction with fingerspelling, speech, and gestures to communicate with each other. Their sign system, which differs from English in structure and syntax, is called American Sign Language (Ameslan), and is a unique language in itself. Today, many educational programs for the deaf are using what is called "Signed English," a modified version of sign language which more closely approximates the English language.

Although research has shown that the very best lipreaders understand only one-fourth of what is said, most hearing parents communicate orally (through speech) with their deaf children, expecting them to lipread. Just because one is deaf, it does not follow that he/she possesses some innate lipreading skill. In fact, the world's best speech-readers are people who are not deaf (Vernon, 1972). Therefore, lipreading leaves a great deal to be desired as a primary means of communication for the deaf.

Statistics show that 91.7 percent of deaf children are born to hearing parents (Schein and Delk, 1974). These parents usually have no idea about what it means to be deaf, nor do they know how to communicate with their deaf children. Most of these hearing parents experience guilt feelings regarding having given birth to a handicapped child. They need counseling, education, and support if they are to understand and communicate with their deaf children.

It is such factors as these -- a war over teaching methodologies, the necessity to focus on speech and language development, existence of guilt feelings in the parents -- which have resulted in the paucity of time and attention given to the personal development of the deaf individual. It is the opinion of the authors that residential institutions may lead to further isolation, thus enhancing the situation in which the deaf are, at best, marginal people. In a few, more progressive schools, administrators are attempting to facilitate interaction between deaf and hearing students by providing sign language classes in hearing schools, as well as through student exchange programs. Deafness, above all else, remains a communication and learning handicap, marked by social isolation, underemployment, undereducation, and underinvolvement in the mainstream of society (Switzer and Williams, 1967).

Contrary to what most people believe, the average deaf person cannot easily gain important information from such sources as books, magazines, or newspapers. Although their IQ's do not vary appreciably from those of their hearing peers, approximately half the deaf students age 20 or below read at less than a mid-fourth-grade level; and only 10 percent of hearing-impaired 18-year-olds nationally can read at or above the eighth-grade level (Trybus and Karchmer, 1977). While reading levels are no index of intelligence, they do indicate comprehension of written language. Since the available written materials are all in English, which is not their primary language, the deaf cannot be expected to read and understand printed material prepared for the average reader. If the deaf are to learn from reading, they must have materials written especially for them.

The limitations imposed by deafness not only restrict the acquisition of general knowledge, but also hinder access to sex information. This reality was demonstrated in 1970, when Steven Grossman used the SKAT (Sex Knowledge and Attitude Test) to compare deaf students from Gallaudet College (the only liberal arts college for the deaf in the world), and hearing students from Pennsylvania State University. According to this unpublished research, the Gallaudet students had less sexual knowledge, were more accepting of sexual myths, and engaged in more sexual activity than the Pennsylvania State freshmen and sophmores with whom they were compared. Furthermore, the average Gallaudet student's level of sexual knowledge did not increase with age. Grossman suggests that perhaps this reflects a need for special sex education programming at Gallaudet College (Grossman, 1972).

As early as 1930, Harry Best compiled statistics indicating that deaf persons marry less frequently and divorce more often than their hearing peers (Best, 1943). Today, by age 34, almost 8 in 10 males in the general population are married, compared with less than 6 in 10 among deaf males. Similarly with females: 84.7 percent of the females in the general public are married, compared with 71.5 percent of deaf females (Schein and Delk, 1974). There are a number of speculations regarding the reasons for these differences. Social isolation, separation from other deaf persons, limited opportunities to develop social skills with the opposite sex, eugenics -- all are among the reasons advanced by theoreticians. Because of social isolation and limited heterosexual contact, the deaf appear to be more vulnerable to marriage difficulties as is reflected in the fact that deaf marriages tend to be somewhat less stable than marriages in general (Schein and Delk, 1974). Currently,

there are few in-depth studies dealing with marriage and divorce among the deaf. Again, too few skilled professionals are able to assist the deaf in couple enrichment, marriage and family counseling/therapy, genetic counseling, and divorce counseling.

Barriers to Receiving Sex Education

The communication and language handicap, and the social isolation imposed by deafness, place serious limits on the availability of sex information to the deaf. Often very natural questions and concerns cannot be readily communicated; discussions may be awkward; answers are not provided. The necessary emphasis upon other educational priorities may preclude allotment of time for a regular program of sex education in the school, even when its importance is recognized.

Although research indicates that 66 percent of the residential facilities for the deaf do provide some formal sex education instruction (Fitz-Gerald and Fitz-Gerald, 1974), the average time devoted to such instruction is only about 47 hours per year. From the topics covered and the time allotted, it can be concluded that the sex education in these schools is often meager and "crisis-oriented."

Who provides the sex education instruction? In 70 percent of the facilities, it is the regular classroom teacher who assumes this responsibility. Have these teachers been trained to assume this responsibility? In 97 percent of the training programs, not one specific course is provided that will facilitate or enhance the teacher's ability to teach sex education (Fitz-Gerald and Fitz-Gerald, 1977, unpublished). Yet it is the teacher, above all others, who is expected to assume this responsibility.

Barriers to Receiving Medical/Counseling Services

Further communication implications can be observed when the deaf person seeks medical services. Can you imagine receiving medical services from a member of the medical profession who does not speak or write English? How comfortable would you feel? How much confidence would you have in the quality of services? This is the exact situation confronting the deaf individual during each encounter with the medical profession, when there are no interpreting services available. What about the medical profession? They, too, often feel uncomfortable because of the responsibility they have and the communication limitations they face. Often a physician will resort to writing or exchanging notes with the deaf patient. The deaf person, not wishing to appear ignorant, will often just nod, even though not understanding.

As a result of communication barriers, counseling services for the deaf are limited, and sometimes even denied. Even when interpreting services are available, the effectiveness of counseling may be open to question. Attempting to establish trust, confidence, and rapport with a client through a third party is difficult, if not impossible. The effectiveness may be further threatened if the counselor appears to have a limited understanding of deafness itself.

Psychosocial Development of the Deaf

To date, very little is known about the psychosexual aspects of deafness. It has been observed that the deaf child is more immature and confused from a psychosexual viewpoint, because he/she does not hear the innuendos and taboos regarding sex, nor have verbal input into male and female development (Myklebust, 1963). In spite of difficulties of

gathering reliable information in this sensitive area, Rainer et al. (1963) concluded sexual delinquency was a more frequent problem in the deaf population than in the hearing population. They suggest that this may be related to general immaturity, to lack of education in the areas of sex and family life, and to residential school living (Schlesinger and Meadow, 1972). Some residential facilities for the deaf continue to segregate activities, thus minimizing heterosexual social interaction. Most dating experiences have been considered "a privilege" and are often permitted only within a group setting.

Traditionally, residential schools have provided for most of the deaf child's educational and personal needs, for the child has spent most of his/her formative years with peers, teachers, and dorm personnel. Many parents, not understanding their deaf children, have given the residential schools full responsibility for both educational and personal development. Many parents feel inadequate to handle sex education with their deaf children and hope that the school will provide it at some level. In turn, many administrators and staff are not comfortable with teaching human sexuality and hope that the parents will handle it at home. Thus, each party assumes that the other is handling sex education, while the deaf child continues as a sexual being with concerns, fears, misinformation.

Just what are the effects of residential life upon the deaf? In all honesty, there is a paucity of research regarding the psychosocial implications of institutionalization. Generally speaking, research tends to indicate that residential life may be less than positive to some aspects of psychosocial-sexual development. It has been observed that social isolation and rate of social interaction are directly related to

role-learning and effective socialization (Goslin, 1969). Therefore, effective socialization becomes more difficult when individuals are isolated from the very system into which they are being socialized. Many deaf persons face isolation not only because they spend their formative years in a residential facility, but also because the primary implication of deafness is that it presents a communication handicap, which, in itself, produces isolation.

Does the deaf individual face greater obstacles regarding gender identity? Ramey, in Intimate Friendships, states that "a boy's concept of maleness and a girl's concept of femaleness is a result of what he/she sees and hears" (Ramey, 1976). If this statement has any validity, then it may hold unlimited implications for the deaf, as well as the blind. Is there evidence of confusion of gender identity in the deaf? There is almost a total dearth of research regarding this topic. The New York study in 1963 by Rainer et al. found that homosexual activity tended to be more common than heterosexual behavior among those males who admitted some sexual experience. Of the total sample, 19.6 percent stated that there was homosexual activity known to them at school. It appears that many deaf males develop a homosexual lifestyle, although there has been no research in this area.

Conclusion

> "Hell," said a Sartre character, "is other people." Nobody knows this better than the disabled. In addition to their disability and the limitations it imposes, they have the additional problem of convincing others that they have the same human desires and impulses (Comfort, 1975).

The deaf, blind, crippled, mentally retarded, and all of the other millions of disabled children and adults are people with sexual needs,

yet all disabled persons share with us a heritage traditionally rooted in avoidance, censorship, and suppression of sexual growth and development. However, this reality is carried even further for the disabled since they are usually societally prejudged either as "not interested" in sex or as "oversexed."

The disabled person's first hurdle in overcoming these stigmas is "self-deprogramming," that is, rejecting the idea that one is not potentially sexual or lovable. The second hurdle is "effective militancy," or doing something about these misconceptions (Comfort, 1975). Both tasks require constant efforts on the part of individual handicapped persons and the professionals working with them.

As a society, we are really just beginning to recognize that the physically and/or mentally disabled are sexual beings, with the same desires, curiosities, hopes, and expectations as any other group of people. Some disabled persons have begun demanding their sexual rights, privileges, and opportunities. As sex educators, counselors, and therapists, we face the challenge and responsibility of reevaluating our own attitudes toward the disabled. Furthermore, we as professionals share in the responsibility of facilitating the development of more open and accepting attitudes in the general public. In conclusion, we would ask: If not now, then when? If not us, then who?

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BEHIND THE TIMES

Della Fitz-Gerald
Max Fitz-Gerald

Sex education for the deaf, as well as for persons with other handicaps, is "behind the times." Of all the problems that deaf people face in our society, those of a sexual and emotional nature are the ones least discussed. Society either denies that deaf persons have "normal" feelings, or else by its financial, physical, and social arrangements makes it difficult for them to express their feelings.

Why is sex education for the deaf not being provided? First, the deaf are victims of what is called "prioritizing." It is often said by educators of the deaf that sex education is important, is needed, but at this time there are more "pressing" priorities. There always have been, and probably always will be, such pressing priorities as language, speech, or a new building. We do not imply that these priorities are inappropriate. However, matters relating to the psychosocial-sexual development of the deaf must receive the same degree of attention if the growth and development of the total child is to be achieved.

Second, the deaf are victims of the attitude that sex education is not really the responsibility of the school, but of the home. It is true that sex education begins in the home, and that parents are a child's first and most important sex educators, but what is taught at home will be far more effective when reinforced at school, and vice versa. With

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family life undergoing rapid and significant change, the home is often unable to provide the appropriate environment necessary for the development of positive attitudes toward sexuality and family life. The birth of a handicapped child into an already changing family can result in additional instability of the family unit. Many deaf children come from one-parent homes, where that parent must work to make ends meet. The financial and emotional strains imposed by such a situation are enormous.

Most deaf children are born to hearing parents, who generally know little about deafness or how to communicate with their children. How do parents answer their children's natural questions about sex when they cannot communicate adequately? What can schools realistically expect homes to provide unless there is willingness to form a partnership of mutual support for the child? As often happens, that which is everyone's responsibility becomes, in reality, no one's responsibility, each person involved assuming that someone else will provide what is needed.

Third, the deaf are victims of the attitude that handicapped people are not sexual beings. All disabled persons share with us a heritage traditionally rooted in avoidance, censorship, and suppression of open discussions of sexual growth and development. This is carried even further for the disabled, since they are usually prejudged by society either as "not interested in sex" or as "oversexed." The first hurdle for the handicapped person in overcoming these stigmas is "self-deprogramming," that is, rejecting the idea that he/she is not potentially sexual or lovable.

What Makes Sex Education for the Deaf Unique?

Are there aspects that make sex education for the deaf different? The overall goals for sex education do not differ in the case of deafness. One is concerned with the development of sexually responsible and informed young persons, deaf or otherwise, who have sufficient knowledge to make appropriate decisions regarding their own sexuality. However, the manner in which such a long-range goal is accomplished does differ. The uniqueness of deafness demands comfort, knowledge, creativity, and sensitivity to the implications of the impairment itself, as well as to the topic, on the part of those involved in the programming.

Deafness is a language/learning handicap that influences social, psychological, and educational development. The uniqueness of the handicap requires comprehensive programming; and, since many deaf children are placed in residential schools, the programming must involve teachers, dormitory staff, administrators, and practitioners, as well as parents and children. Each of these persons is important in developing a quality sex education program for the deaf child.

When a person cannot hear, he/she becomes dependent upon visual stimuli. With or without a hearing aid, the deaf child depends chiefly upon sight for clues. The deaf child's tools are nonverbal and visual communication, such as pointing, acting out, gesturing, and/or pantomime. Although the deaf child is isolated from the world of sound, concrete ideas are usually communicated very well nonverbally, but abstract concepts like motherhood, relationship, and pregnancy are not as easily understood. Parallel to the development of conceptualization is linguistic development. The deaf child labors over simple English sentence order, pluralization, tenses, word endings, and so on. Simple idioms, expressions, and innuendos are often lost to him/her. Speech development

becomes a struggle as the deaf child attempts to imitate sounds never heard or greatly distorted. Without a solid language foundation, reading becomes difficult, if not impossible. Low-level achievement becomes the rule. Deaf youth, therefore, are forced to use a graphic, nonverbal communication system, including gestures, drawings, homemade signs, and/or sign language, for human contact and interaction. For example, a young deaf child pointing to his/her genitals or imitating urination might be expressing a desire, asking a question, or indicating knowledge or experience. Such overt nonverbal communication is usually curbed by adults, but the young deaf person invents signs or picks up American Sign Language (a graphic system unique to the deaf). Such a sign system allows for personal exchange. The deaf adolescent quickly learns the taboos of being so graphic, and carries his/her communication "underground." Thus, even more barriers are built up to prohibit communication and interaction.

The Role of Parents

The parents of 91.7 percent of all deaf children are hearing persons (Schein and Delk, 1974), most of whom have little understanding of deafness. For many of these parents, the first contact with deafness is through their own deaf child (Levine, 1954). They may experience frustration, anger, and guilt upon discovering the handicap. The first five years of the child's life are often spent in seeking a correct diagnosis of the problem. Repeated misdiagnosis may occur. According to one survey, one-third of the parents of deaf children were told that their children were not deaf by the first physician consulted, and 66 percent had to see four or more physicians before a correct diagnosis was

made (Schlesinger, 1972). Parents understandably become angry and frustrated, sometimes "taking it out" on the child, even though they realize that the child is not to blame (Vernon, 1971).

Hearing parents often exhaust their energies coping with their own frustrations, thus leaving little strength to delve into the psychosocial-sexual concerns of their children. It is also true that few parents receive guidance and/or counseling for their own personal growth, especially time spent on helping them to become comfortable with their own sexuality. Attitudinal extremes from overprotectiveness to laissez faire can be observed. As a result, parents' relationships with each other may suffer. One survey of the parents of students attending a leading West Coast school for the deaf indicated that two-thirds were divorced (Vernon, 1971).

Hearing parents sometimes foster dependence of their deaf children upon themselves. These deaf children then grow into adulthood unprepared for mature interdependent relationships. When, in turn, they become parents of hearing children, they may transfer their dependence to these children, thus forcing the children to assume adult roles prematurely. Small wonder, perhaps, that deaf persons marry in smaller proportions than hearing persons, and that their marriages prove less stable (Schein and Delk, 1974).

Good child sex education evolves from good parent education. It is unreasonable to expect parents of deaf children to be knowledgeable or accepting of their children's sexuality when they may not be comfortable with their own. Most parents did not receive their sex education from their parents, so they have had few, if any, models to guide them. To be effective, parent education must begin by providing parents themselves

with models, knowledge, and opportunities to enhance their "comfort levels."

The Residential School

Many deaf children are educated at residential schools, sometimes leaving home by the time they are four or five years of age. Surrogate parents in the form of teachers and houseparents become very important models in the life of a child living in such a situation. Development of sex-role behaviors becomes very important in a residential school, since deaf children have few opportunities to observe and interpret such behaviors in their own families (Schlesinger and Meadow, 1974).

Within residential settings, there are few opportunities for privacy. Adult supervision in the form of a teacher, dorm person, or administrator is constantly present. Males and females are separated for most activities. Leisure time for informal opposite sex communication and interaction is limited and usually highly structured. A general policy of a progressive residential school in 1970 read as follows:

> Dating as such is not permitted. The school provides as many opportunities as possible for boys and girls to mix socially. These activities are necessarily group activities since there are a limited number of staff members to provide supervision, and supervision unfortunately (from the children's point of view) is necessary . . . . Aside from the very practical consideration of avoiding pregnancies and sexual misbehavior, supervision of boy-girl activities provides counselors with the opportunity to promote attitudes of respect and mutual consideration among the students (Schlesinger and Meadow, 1974).

Many questions are raised by such a policy: Can healthy attitudes toward sexuality be developed in such a situation? How can young people acquire positive feelings about male/female relationships in such a restrictive atmosphere? What kinds of foundations for marriage and adult relationships are being built here?

Houseparents. It has been the authors' experience that dorm personnel, or "houseparents," have been inadequately trained to handle this parental/supervisory role. They are often unaware of the psychosocial implications of deafness. Although there have been some in-service training programs in recent years at Gallaudet College, only a few persons have attended them. Some dormitory staff communicate orally and never learn sign language even after many years of experience. It is not unusual for "houseparents" to be responsible for a considerable number of children at one time. Most dormitory personnel are underpaid and overworked. In the authors' opinion, it is questionable whether healthy and appropriate surrogate parenting is possible under such conditions. Again, a small number of the more progressive schools are realizing that houseparents are equally as important as teachers. This has resulted in the hiring of trained teachers and counselors as houseparents.

Many opportunities for sex education occur naturally in the dorm. Sexual exploration, acting out, and imitation frequently evolve as the children interact. Houseparents often assume one of two roles: that of ostrich or of disciplinarian. In many schools, houseparents are required to supervise students at all times except when the students are in class. Such regulations completely deprive young people of privacy, as social interaction is permitted only in large groups and within restricted environments.

Since some houseparents do not know how to communicate with deaf children, opportunities for intimate discussions are limited or even precluded altogether. The houseparent's role becomes chiefly custodial, as he/she wakes and bathes the children and oversees dorm housecleaning. Many opportunities for significant discussions are lost.

The Administrator. Traditionally, administrators have assumed a caretaking role in the deaf child's life. Most instructional efforts have called for "priorities" in speech and language skills. More recently there has been a trend toward career and vocational development as well. Today, speech, language, career, and vocational development are greatly focused upon, often to the neglect of psychosocial-sexual development. Based upon 10 years of experience in residential and day programs, it is the authors' opinion that many administrators are aware of the sexual curiosities and exploratory behavior of students. However, they are often unprepared and/or unwilling to provide appropriate instruction for either students or staff on how to deal constructively with these natural phenomena. Education for sexuality is often handled by implying that such instruction is the responsibility of the parents, or by burying one's head in the sand in the vain hope that if one does not talk about sexuality, it will simply go away.

The Practitioner. Our earlier research indicates that 70 percent of the time, the classroom teacher assumes the sex educator role in residential facilities (Fitz-Gerald and Fitz-Gerald, 1976). This is not surprising when one observes that the teacher expects, and is expected, to be the "educator, surrogate parent, psychiatrist, friend, nurse, etc.," to the deaf child (Schlesinger and Meadow, 1972). Health and science teachers are the ones most frequently asked to assume responsibility for sex education. To date, only 3 percent of the teacher-training programs in education of the deaf provide any training for sex education instruction (Fitz-Gerald and Fitz-Gerald, 1977). A degree in education of the deaf is not sufficient preparation for assuming a sex educator role.

The sex educator of the deaf must possess many competencies. Ability to communicate with the deaf and knowledge of the implications of deafness are both basic. Application of this knowledge and communication are possible only when the practitioner feels comfortable with his/her own sexuality and that of others. Adequate preparation is vital. When working with deaf youth in sex education, the level of comfort is paramount. The young deaf person will act out graphically, signing and pointing. Such behavior must not be regarded as affront, or rudeness, much less as abnormality or delinquency. Rather, it is very likely the only way that the deaf person can express his/her personal sexual concerns. The practitioner must be aware of the local signs and be able to accept the graphic gestures used. The personal communicative skills of the deaf educator may require a greater degree of comfort than is necessary for the sex educator of hearing youth. The implications of deafness require the sex educator to be a skilled modifier and inventor of materials, as well as an educator and communicator.

Characteristics of Sex Education for the Deaf

Sex education for the deaf requires highly visual materials supported with simple language. For example, the statement "Boys become men" entails the necessity of determining that the three word-concepts are understood, that the plural is understood, and that the deaf person has a visual image of the meaning of the written concept. Concepts like "maturing," "menstruation," and "pregnancy" must be reduced to simple terms for the deaf adolescent. Pictures, films, photographs, role-playing, and experiential situations are important tools in making concepts about sexuality understood. Concrete visual information can

easily be presented; however, care should be taken to prevent locking young deaf people into rigid conceptualizations. Because values and behaviors tend to be somewhat abstract, situational games and role-playing can be useful tools in developing an understanding of values and lifestyles.

Few sex education materials especially designed for the deaf population are available. Modification of existing materials and media becomes necessary. The average deaf adolescent would be insulted by the material written at his/her actual reading level. Brainstorming, invention, and modification become bywords. No matter how relevant the subject may be, if the deaf youth has to struggle with comprehension, interest will be lost. Thus, opportunities for sex education will also be lost.

Television programs, magazines, and movies elicit many responses from deaf youth, usually in the form of "acting out." Affection, romance, or copulation may be imitated in the classroom, dormitory, or on the playground. These behaviors must be explained via sign language, gestures, or acting out. Presently there are very few formal local sex education signs and no universal signs. Deaf children learn the American Sign Language sex vocabulary from the adult deaf, or they invent their own graphic gestures. Their need to communicate is great, and they will do so in the best way they can.

Where Do We Go From Here?

Even though sex education for the deaf is behind the times, the picture is not totally bleak. There have been in the past, and there are today, scattered attempts to provide sex education. The real hope,

however, lies with deaf people themselves. In recent years, movements have developed within the deaf community expressing "deaf pride" and "deaf power," as deaf people have taken greater initiative than ever before in directing their own affairs and shaping their own destiny. This was recently demonstrated by a proposal of the National Association of the Deaf for a grant from the Bureau of Education of the Handicapped, to be used for the development of materials and media on sex signs for parents and professionals.

During the spring of 1977, a group of deaf women invited the authors to lead a workshop on "Sexual Concerns of Deaf Women." This workshop was so successful that it has generated plans for a second one, to be presented in the early fall of 1977, this one to include men as well as women.

The deaf, like other handicapped persons, are demanding that their rights to sexual awareness, understanding, and fulfillment no longer be denied. These are rights shared by all. An old Chinese proverb says, "Help thy brother's boat across, and lo, thine own has reached the shore." Perhaps, by following that philosophy in providing sex education for the handicapped, it may turn out that the result will be greater growth and enrichment for everyone. In conclusion, actions often speak louder than words. It is a simple matter to state that education for sexuality is needed, is important for the deaf. It is yet another thing to put those words into action. Where is the action?

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SEXUAL IMPLICATIONS OF DEAFNESS

Della Fitz-Gerald
Max Fitz-Gerald

Learning about one's sexuality occurs both formally and informally through one's life cycle and many opportunities are normally provided in one's environment. Individuals learn about their sexuality in three significant ways: (1) directly (from personal experience), (2) indirectly (from talking or reading about it), and (3) through observation (from listening to and watching others). When a physical or mental impediment interferes with this learning process, the more natural opportunities for learning about sexuality are limited and often are not available. A hearing impairment can be such an impediment. What does it mean to have a severe hearing impairment early in life? What are the effects of such a loss on one's psychosexual learning process? What are the implications for the professional? Each of these questions will be explored.

A hearing loss can be understood as a continuum ranging from mild to profound with etiology stemming from a variety of sources. An impairment of hearing is the single most prevalent chronic physical disability in the United States today. More persons are affected by a hearing defect than have visual impairments, heart disease or any other chronic disability. A fairly accurate estimate of the number of people affected by such an impairment was made in 1974. The National Census of the Deaf Population (NCDP) represented the first major effort, since the 1930 United States Census, to identify the number in our society with hearing

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impairments. From these statistics it has been estimated that there are 13.4 million persons in the U.S. with a hearing impairment, 1.8 million of whom can be classified as deaf.[1]

Deafness, the extreme end of the hearing impairment continuum is often referred to as the "invisible handicap." That is, the physical effects of deafness are not as obvious to the naked eye as are those associated with blindness, cerebral palsy or other physical impairments. However, the invisibleness of deafness is not always a blessing. Often, the educator or health professional, unless directly confronted with deafness, is not aware or informed of the possible severe educational, vocational and social handicaps imposed by the impairment. From time to time, one will express, in jest, that it would be better not to be bothered by all the noise pollution. However, one may not realize that such a "luxury" of quietness would also require giving up the ability to receive verbal feedback, a most important link in communication.

Deafness refers to a profound hearing impairment which requires the person so affected to use primarily a visual means of communication. Thus everyday auditory communication or speech is not heard or understood. In order to better understand the implications of deafness, it is important to distinguish between those who are born deaf (congenitally deaf) and those who become deaf (adventitiously deaf).[2] The adventitiously deaf are further separated into those who lost their hearing prior to the acquisition of speech and language (prelingually deaf) and those who lost their hearing after the acquisition of speech and language (postlingually deaf).[2] Obviously, the severity of the implications of deafness is greater with the congenitally and prelingually deaf. Since the ability to use language is basic to learning, the deaf are deprived

of a great deal of knowledge that their hearing peers receive continually and often effortlessly.

This deprivation is poignantly illustrated by the fact that, although deaf persons' I.Q.'s do not vary appreciably from those of their hearing peers, approximately half the hearing impaired aged 20 or below read at less than a mid-fourth grade level and only 10% of hearing impaired 18 year olds nationally can read at above the 8th grade level.[3] While reading levels are no index of intelligence, they do indicate comprehension of written language. Since the available reading materials are all in English (which is not their primary language), the congenitally and prelingually deaf cannot be expected to read and understand printed material prepared for the average reader. In fact understanding both written and verbal communication becomes very difficult for the deaf. Yet most deaf youth are expected to lipread very early in life.

Statistics show that 91.7% of deaf children are born to hearing parents.[1] These parents usually have no idea about what it means to be deaf, nor do they know how to communicate with their deaf children. Although research has shown that the very best lipreaders understand only one fourth of what is said, most hearing parents communicate orally (through speech) with their deaf children, expecting them to lipread. Just because one is deaf, it does not follow that he/she possesses some innate lipreading skills. In fact, the world's best speechreaders are people who are not deaf.[4] Therefore, lipreading leaves a great deal to be desired as a primary means of communication for the deaf.

Sign language is the preferred mode of communication among most of the deaf.[5] Most deaf persons today use some type of hand signaling system in conjunction with fingerspelling, speech, and gestures to

communicate with each other. Their sign system, which differs from English in structure and syntax, is called American Sign Language (Ameslan), and is a unique language in itself. Today, many educational programs for the deaf are using what is called "Signed English," a modified version of sign language which more closely approximates the English language. However, there has not been sufficient time to determine if this communication system has been effective in fostering the development of English.

Thus, with this brief background into deafness one may be better able to understand some of the implications for the development of a healthy sexuality for the deaf person. Personal experience and watching become the most significant avenues for learning for the congenitally and prelingually deaf.

Psycho-Sexual Development of the Deaf

To date, very little is known about the psychosexual aspect of deafness. It has been observed that the deaf child is more immature and confused from a psychosexual viewpoint, because he/she does not hear the innuendos and taboos regarding sex, nor have verbal input into male and female development.[6] In spite of difficulties of gathering reliable information in this sensitive area, Rainer et al. (1963) concluded that sexual delinquency was a more frequent problem in the deaf population than in the hearing population.[7] They suggest this may be related to general immaturity, to lack of education in the areas of sex and family life, and to residential school living.[8] Some residential facilities for the deaf continue to segregate students by sex or constantly chaperone them except during classroom activities, thus minimizing heterosexual

social interaction. Most dating experiences have been considered "a privilege" and are often permitted only within a group setting.

Traditionally, residential schools have provided for most of the deaf child's educational and personal needs, for the child has spent most of his/her formative years with peers, teachers, and dorm personnel. Many parents, not understanding their deaf children, have given the residential schools full responsibility for both educational and personal development. Many parents feel inadequate to handle sex education with their deaf children, and hope that the school will provide it at some level. In turn, administrators and staff are hopeful that parents will handle it at home. Thus, both parties assure themselves that the other party is handling sex education, while the deaf child continues to be a sexual being with concerns, fears, and a surfeit of misinformation. Many deaf adults have grown up in residential facilities where extreme sexual segregation has been the rule, not the exception, and where heterosexual social interaction was minimal. For example, most dating in residential schools has been considered a privilege and has been permitted only in group dates and/or with chaperones. Rainer and Altshuler polled a representative sampling of deaf adults in New York state and found that 51.8% reported having had no dates while in school, while only 7.7% of these adults had experienced individual couple dating. None of the women had had sexual experiences and a large number of men had not. Nineteen and six-tenths percent had experienced homosexual behavior.[7] Formal sex education has been almost nonexistent and informal opportunities for heterosexual interaction has been extremely limited. Such an environment often creates barriers to social interaction and to adequate socialization with both sexes.

Within residential settings, there are few opportunities for privacy. Adult supervision in the form of a teacher, dorm person, or administrator is constantly present. Males and females are separated for most activities. Leisure time for informal opposite sex communication and interaction is limited and usually highly structured. A general policy of a progressive residential school in 1970 read as follows:

> Dating as such is not permitted. The school provides as many opportunities as possible for boys and girls to mix socially. These activities are necessarily group activities since there are a limited number of staff members to provide supervision, and supervision unfortunately (from the children's point of view) is necessary.
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> Aside from the very practical consideration of avoiding pregnancies and sexual misbehavior, supervision of boy-girl activities provides counselors with the opportunity to promote attitudes of respect and mutual consideration among the students.[8]

Many deaf children educated in residential schools leave home by the time they are four or five years of age. Surrogate parents in the form of teachers and houseparents become very important models in the life of a child living in such a situation. Development of sex role behaviors become very important in a residential school, since deaf children have few opportunities to observe and interpret such behaviors in their own families.[8]

Just what are the effects of residential life upon the deaf? In all honesty, there is a paucity of research regarding the psychosocial implications of institutionalization of the deaf. Generally speaking, research tends to indicate that residential life may be less than positive to some aspects of psychosocial-sexual development. It has been observed that social isolation and rate of social interaction are directly related to role-learning and effective socialization.[9] Therefore, effective socialization becomes more difficult when individuals are

isolated from the very system into which they are being socialized. Many deaf persons face isolation not only because they spend their formative years in a residential facility, but also because the primary implication of deafness is that it presents a communication handicap, which, in itself, produces isolation.

When a person cannot hear, he/she becomes dependent upon visual stimuli. With or without a hearing aid, the deaf depend upon sight for clues. The deaf person's tools are non-verbal and visual communication, such as pointing, acting out, gesturing, and/or pantomime. The deaf are isolated from the world of sound. Usually, concrete ideas are communicated very well non-verbally, but abstract concepts like motherhood, relationship, and pregnancy are not as easily understood. Parallel to the development of conceptualization is linguistic development. The deaf person labors over simple English sentence order, pluralization, tenses, word endings, and so on. Simple idioms, expressions, and innuendos are often lost to him/her. Speech development becomes a struggle as the deaf individual attempts to imitate sounds never heard or greatly distorted. Without a solid language foundation, reading becomes difficult, if not impossible. Low-level achievement becomes the rule. The deaf, therefore, are forced to use a graphic, non-verbal communication system, including gestures, drawings, homemade signs, and/or sign language, for human contact and interaction. For example, a young deaf child pointing to his/her genitals or imitating urination might be expressing a desire, asking a question, or indicating his/her knowledge of an experience. Such overt non-verbal communication is usually curbed by adults, but the young deaf person invents signs or picks up American Sign Language (a graphic system unique to the deaf). Such a sign system allows for personal

exchange. The deaf adolescent quickly learns the taboos of being so graphic, and carries his/her communication "underground." Thus, even more barriers are built up to prohibit communication and interaction and the deaf person is further isolated.

Understanding such abstract concepts as maleness, femaleness, parenting, relationships, and reproduction becomes secondary when one has to struggle with the basic labeling of one's body parts. For example, the average hearing person, upon hearing a word several hundred times, usually can integrate that word into his/her vocabulary. The deaf person, young or old, is denied the verbal repetition and ultimately the word itself. For the deaf person, the integration of just one word into the vocabulary requires that someone point out, show, demonstrate again and again that which is being taught. Such deprivation is not usually remedied with age. Observation and actual experience remain the primary modes of learning about sexuality for the deaf adolescent and adults as well.

The reality of the implications of the isolation of deafness has been further validated in 1970, when Steven Grossman used the SKAT (Sexual Knowledge and Attitude Test) to compare college students from Gallaudet College (the only liberal arts college for the deaf) and Pennsylvania State University. According to this unpublished research the Gallaudet deaf students had less sexual knowledge, were more accepting of sexual myths and engaged in more sexual activity than the Pennsylvania State freshmen and sophmores with whom they were compared. Furthermore, the Gallaudet deaf students' level of sexual knowledge did not increase with age. Grossman suggested this reflected the lack of

formal sex education programming at Gallaudet.[10]

As early as 1930 Harry Best compiled statistics that indicated deaf persons married less frequently and divorced more often than their hearing peers.[11] Today by age 34, almost 8 in 10 males in the general population are married as compared to less than 6 in 10 deaf males. The same applies to females as 84.7% of the females in the general public are married as compared to 71.5% of the deaf females.[1] There are a number of speculations regarding these differences such as: social isolation, separation from other deaf persons, limited opportunities to develop social skills with the opposite sex and eugenics. (Interestingly enough 88% of children with deaf parents are hearing).[1] Due to social isolation and limited heterosexual contact, the deaf appear to be more vulnerable to marriage difficulties. Currently there are no reliable divorce statistics among the deaf. However, a large number of divorces among deaf professionals can be observed.

Implications for Residential Schools and Agencies

One of the first efforts to develop professional awareness of the need for a formal sex education program for the deaf was attempted in the early 40's when Stanford Blish published an extensive series of articles on sex education and the deaf child. Results of this first effort were mixed and met with very limited efforts in program development within residential facilities. By the late 50's various individuals had begun implementing a variety of health and hygiene courses in the schools for the deaf. The Illinois School for the Deaf, the Clarke School for the Deaf and New Jersey School for the Deaf were among the first.

In 1966 a major effort was made to determine: (1) the residential schools' for the deaf policies and programs with respect to dating and social relationships among the deaf teenage students and (2) provision of family life education. Of the 66 residential schools for the deaf surveyed sixty schools (90.9%) responded to the survey. Responses indicated that 85% of the schools permitted dating in some form. Approximately 53% allowed students to date off campus. However, in most cases, off campus dating was limited to group activities. Formal sex education classes were given in thirty (50%) of the responding schools.[12]

In 1972 a similar survey was conducted in an effort to determine the status of sex education and drug abuse in various residential schools. Surveys were sent to 125 schools with a deaf student population of at least fifty. Seventy (56%) of the surveys were returned. Seventy percent of the 56% who responded to the survey indicated that they provided a sex education program for the deaf students.[13]

With the assistance of the offices of Public Relations and Demographic Studies of Gallaudet College in 1974, a more inclusive survey was developed and distributed to 112 residential facilities for the deaf (excluding post-secondary programs). According to the respondents, minimal programming was provided at the primary level while most programming existed at the secondary level. One of the most enlightening questions asked was, "How many hours per school year are devoted to sex education?" This ranged from as low as one hour per year to as high as 720 hours per school year. This particular question supported the reality that even though 66% of the residential facilities have a "formal" sex education program, a great deal of this instruction was "meager," as well as "crisis" oriented in nature. The classroom teacher

By later adolescence and adulthood many concerns surround birth control. Many deaf college students and deaf adults believe withdrawal to be a method of birth control. According to the Grossman study, 38% of the Gallaudet coeds tried withdrawal while another 30% tried the rhythm method.[10] It appears that 68% of this sample used less than reliable sources of birth control. Unwanted pregnancies and/or children, rushed marriages or quick abortions often result from this lack of knowledge concomitant with bitter feelings and resentment. The paucity of understanding about birth control is reflected in the selection of the sign for birth control, which generally means "birth control pill." Further misunderstanding about the use of birth control is reflected by the surfeit of myths and misinformation shared by many deaf men and women. Obviously such incomplete and false information can result in severe problems in sexual relating and communicating.

The Role of the Sex Counselor

It becomes necessary for the sex counselor to be not only skilled at communicating with the deaf but knowledgeable of deafness and sexuality. Such skills do not mean instant success. Even when there is no communication problem for the professional, sex counseling/therapy is often a very slow, complex process with the deaf for this process is often compounded by the fact that the deaf persons may not have accepted their own deafness. Sometimes the degree of difference in hearing between two partners presents difficulties. The fact that the deaf person may not trust hearing people is an additional issue that emerges for the hearing professional. There is also the task of re-asking questions to be sure that there has not been a conceptual

misunderstanding about a particular point being made. Needless to say, such a process requires extraordinary time and patience for both the counselor/therapist and client.

Conclusion

Does the deaf individual face greater obstacles regarding gender identity? Ramey, in Intimate Friendships, states that "a boy's concept of maleness and a girl's concept of femaleness is a result of what he/she sees and hears."[17] If this statement has any validity, then it may hold unlimited implications for the deaf, as well as the blind. Is there evidence of confusion of gender identity in the deaf? There is almost a total dearth of research regarding this topic. The New York Study of 1963 by Rainer et al., found that homosexual activity tended to be more common than heterosexual behavior among those males who admitted some sexual experience. Of the total sample, 19.6% stated that there was homosexual activity known to them at school.[7] It appears that many deaf males choose homosexual lifestyles, although there has been no research in this area. The reasons for the lack of research are both obvious and numerous. With respect to deaf children, there is the question of whether the development of homosexual tendencies is facilitated by the effect of early total deafness, residential life, or a combination of these factors.

Many deaf persons are concerned and becoming aware of the deaf communities' lack of sexual knowledge and opportunities for personal growth. Other handicapped persons, including the deaf, are demanding that their rights to sexual awareness, understanding, and enjoyment no longer be denied. These are rights shared by all. An old Chinese

proverb says, "Help thy brother's boat across, and lo, thine own has reached the shore." Perhaps, by following that philosophy in providing sex education and counseling for the handicapped, it may turn out that the result will be greater growth and enrichment for everyone. As sex educators, counselors and therapists we face the challenge and responsibility for reevaluating our own attitudes toward the disabled. Furthermore we, as professionals, share in the responsibility of facilitating the development of more open and accepting attitudes in the general public. It is a simple matter to state that education/counseling sexuality is needed, is important for the deaf. It is yet another thing to put those words into action. In conclusion, we would ask: If not now, then when? If not us, then who?

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THE SEX EDUCATOR:
WHO'S TEACHING THE TEACHER SEX EDUCATION?

Della Fitz-Gerald, Max Fitz-Gerald, and Clarence M. Williams

Learning about one's sexuality occurs both formally and informally throughout one's life cycle and many opportunities are normally provided in one's environment. Individuals learn about their sexuality in three significant ways: (1) directly (from personal experience), (2) indirectly (from talking or reading about it), and (3) through observation (from listening to and watching others). When a physical or mental impediment interferes with this learning process, the more natural opportunities for learning about sexuality are limited and often are not available. Obviously such handicapping conditions increase the responsibilities of both the home and the school to facilitate the development of a child in this area of concern.

The role our schools are assuming in teaching sex education appears to be growing. The United States Office of Education has stated that it "will support" sex education as an integral part of the curriculum from preschool to college and adult levels (U.S. Commission on Education, 1966). A recent Gallup poll indicated that more than 7 out of every 10 parents favor sex education as part of the school curriculum (McCary, 1973). Recently completed research indicates that 77% of the state residential schools for the deaf already provide some type of sex education instruction (Fitz-Gerald & Fitz-Gerald, 1976).

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This is not to imply that despite the increasing attention being given to sex education that everyone supports it, nor should it be claimed that the school, not the home, is the most appropriate place for such instruction. There are both pros and cons for either side of the argument. It is not our intent to discuss either the need for or the place of sex education. The primary concern here is with the preparation of the teachers who are already assuming this responsibility.

What is Sex Education?

"Some educators refer to sex education as just that, others prefer to use the phrase 'education of human sexuality.' It is really in this broader context that any significant discussion of sex education must take place" (Schiller, 1973).

Sexuality is reflected in the way an individual dresses, speaks, behaves, walks, and feels about himself and others. Therefore, sex education must be reality oriented, taking into consideration that our sexuality is at the very core of our personal identity (Schiller, 1975). Sex means things other than sexual intercourse . . . "it means all the ways that men and women are different: how they act, how they dress, how they move, how they talk, how they think, how they feel, how they play, what kind of jobs they do, and how their bodies are made" (Johnson, 1970). In fact no other single force influences a person's life as much as membership in one or the other sex (Kirkendall, 1950).

Sex education has been defined as instruction to develop an understanding of the physical, mental, emotional, social, economic and psychological phases of human relations (Wolfram, 1968). One can say sex education consists of instruction to develop an awareness and

understanding of the complex components of human relationships. In essence, sex education is an attempt to teach [illegible]ividual how to make the best possible decision regarding his/her sexual expression from among the seemingly ever increasing options.

Whatever the final definition, supporters of a sex education program must have knowledge of what it is they support and what they expect from it. Those who are responsible for providing the actual instruction must have a clear understanding of the objectives towards which they are to work.

Teacher Preparation

If the teaching of sex education is to be shared by our schools, who is and who is not qualified to teach it? It is vital to note that only a decade ago that there were few, if any, courses available in sex education. To date, at no university in this country does there exist a formal degree program in sex education. It has only been within recent years that a person could become certified as a sex educator through a limited program of the American Association of Sex Educators, Counselors, and Therapists through American University in Washington, D.C. Still limited opportunities for training are available to interested professionals. Furthermore, there are very few sex education specialists currently employed by either private or public schools for the deaf. This results in existing staff members becoming responsible for sex education instruction and programming. It has been recently shown that the classroom teacher was the sex education instructor in residential schools 70% of the instances where sex education was provided (Fitz-Gerald & Fitz-Gerald, 1976). Due to the perceived

personal and sensitive nature of sex education, special skills become important for the sex educator and appropriate training becomes even more important.

The sex educator must first of all possess both a desire and an interest in teaching sex education. This may sound trite at first; however, a teacher should not be forced to function deliberately in such a role against his/her wishes. Second, the teacher should be as comfortable, as possible, with his/her own sexuality, as well as that of others. Third, the teacher must possess adequate knowledge and understanding of the subject matter and human developmental processes. These represent the fundamental competencies and attitudes of the sex educator and are equally important, for if any of the three is missing, success of the sex education program is jeopardized.

Are classroom teachers prepared to assume the role of sex educator? This question was asked of those in charge of 734 teacher training programs in the United States. Of the 250 (34%) who responded to the survey, only 21 (8%) offered a specific course or courses intended to prepare teachers to teach sex education (Malfetti, 1969). If this survey is representative of public school teacher training programs, what is the degree of training provided by programs that train teachers of the deaf?

Methodology

A telephone survey of the 71 teacher training programs of the deaf as listed in the April 1976 Annals was conducted in January, 1977. Responses were received from each of the programs. Each respondent was asked four questions:

Question #1

Does your teacher training program offer a specific course or courses designed to prepare its trainees to teach sex education?

Response

Of the 71 teacher training programs, only 2 (3%) provide a specific course.

Question #2

Is such training included as part of another course?

Response

39 (57%) indicated that such training is included as part of other courses such as:

Methods and Curriculum;

Psychology and Deafness;

Science Curriculum;

Health and Family Living; and

Parental Concerns.

However, additional comments indicated that sex instruction content was:

very limited;

just briefly considered; and

there was not enough being done to prepare teachers to assume this responsibility.

Comments from the 30 (43%) respondents who do not provide this instruction as part of another class were:

part of special education;

health and physical education does it;

it is an elective offered by the college of education; and

it is provided in general classes on sex, drugs and alcohol.

Question #3

Do you believe there exists a need to prepare teachers to function in the role of sex educator?

Response

60 (83%) indicated that they believed that there was such a need. Additional comments were:

time problem with meeting requirements;

need for greater program flexibility;

provide training for those levels where needed; and

training should be provided while student is in regular educational program.

11 (11%) indicated that there was not a need to provide this type of the instruction. Additional comments were:

teachers should pick up this information on their own time;

physical education should provide it;

it's not a priority; and

it's not a responsibility of the classroom teacher.

Question #4

What, if anything, could a facility such as Gallaudet College do to facilitate your efforts to prepare teachers as sex educators?

Response

Frequency	Response
18	Develop multi-media packages for all age levels
17	Provide workshops for teacher trainees
15	Provide workshops for college faculty
11	Develop a curriculum for faculty to use
9	Develop curriculum to be used in day and residential programs
9	Develop models that can be inserted into current training programs
5	Provide more and better captioned films
4	Develop model programs at KDES and MSSD
3	Develop any kind of instructional material
3	Provide consultants who can go out into the field and work with faculties
3	Develop materials for the multi-handicapped
3	Anything would help
3	Provide assistance for day programs
3	Determine what are the legal requirements of each state
2	Develop a pilot training program for teachers
1	Develop appropriate sign language
1	Provide more information and research on heredity and deafness
1	Identify skills needed by teachers who serve as sex educators

1 Develop materials regarding gender identity

1 Keep the profession informed of what others are doing

1 Inform teachers and parents about materials that are available

1 Provide workshops for parents

Conclusion

All of the information found represents areas of concern and need across the entire United States. The majority of the 71 telephone conversations reflected the belief that significant changes must be made to provide quality sex education for the deaf. For example, many respondents see the need for facilitating media packages, workshops for trainees and college faculty, curriculum for faculty and students and model programs. A smaller number desire assistance in day programming, pilot teacher trainee programming, development of appropriate sign language, research, professional sharing and parent workshops.

The kind of sex education obtainable for our children, as well as ourselves cannot always be controlled in our society. However, we can begin to improve instruction by insuring that those who provide sex education instruction in our schools have the benefit of an adequately designed sex education training program. Our data indicates that sex education training was a limited part of other courses in 57% of the training programs, while 43% of the training programs indicate sex education instruction to be the responsibility of other departments or programs. The impression gained from some of the respondents was that what is everyone's responsibility becomes, in reality, no one's, as each individual assumes that the other is providing it. The respondents made no mention of the individual training program assuming responsibility for

inservice training for its staff.

If the past is any indicator of the future, our schools and programs for the hearing impaired child will play an ever increasing role in sex education. This survey finds that 11% of the respondents see no need for sex education instruction. Yet the need will become more evident as the influence of the family is modified through such things as an increasing divorce rate and one-parent homes. More responsibility will accrue to the school, as a result of the growing trend of both parents pursuing careers outside of the home. It seems reasonable to expect that facilitating the contemporary family's ability to provide the nurturing environment a child needs is the greatest challenge facing educators. However, one must not lose sight of the fact that parents are a child's first and most influential sex educators. Skills in parent education become a very important aspect of teacher preparation. Finally, it must be remembered that to be hearing impaired really implies a language impairment which ultimately means a communication impairment. It is the latter impairment that most often results in misunderstandings, false interpretations, and limited access to appropriate information.

How effectively educators are able to meet both the challenge and the responsibility before them will primarily be determined by how well prepared are those who teach. Both preservice and inservice training become necessary. A sex education program is no better than those who are charged with the responsibility for instruction.

What can Teachers and Parents Do Now?

Since becoming comfortable with one's sexuality is a developmental process, it is important that all significant adults surrounding the

child try to become comfortable with their own sexuality. This is not always immediately possible but teachers, parents, and administrators can sit down together and share their mutual concerns for the deaf child's development of a healthy sexuality. There is much in the way of knowledge and support that each can offer the other. Parents are the first and most significant sex educators. They can and are more than willing to "share" this responsibility with teachers and administrators. The word share is emphasized since any educational program must be a joint effort, if it is going to provide the best instruction for the deaf child. Schools should not and cannot replace the role of parents. However, they can support and facilitate parents by involving them in school programming. To approach sex education in any other manner is to court disaster.

Joint efforts to define a sex education program must include both preparation and selection of trained staff. Our research has examined the status of training programs and their role in preparing sex educators. Parents and school staff together can insure the quality and training of the sex educator(s) of the deaf by being aware of the current training efforts, requiring specific training and/or providing appropriate training programs. Only through careful screening of and adherence to requirements for the sex educator can the deaf child obtain the sex education he/she has a right to expect and receive. Both professionals and parents share in this very special right. The key is placing their child with the best prepared sex educator(s).

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SEX EDUCATION SURVEY OF RESIDENTIAL FACILITIES FOR THE DEAF

Della Fitz-Gerald
Max Fitz-Gerald

All residential facilities for the deaf are involved, either formally or informally, in the process of teaching sex education. Information, attitudes and societal expectations are continuously being disseminated on both a conscious and unconscious level in the classroom, the dormitory or on the playground. By their very nature, residential facilities are placed in the position of having to provide numerous familial services concomitant with those provided by the family. Among these services is that of sex education. The task before us was to attempt to determine what formal efforts were currently being made by residential facilities for the deaf to provide sex education instruction. For example: in what context, how and where it was provided (department, dormitory), to whom, by whom, when, for what duration of time and what the instruction included?

During this project we became aware of the excellent studies by Scott and Adams (1973) and Craig and Anderson (1966). These studies collected valuable data concerning: the academic levels at which sex education was offered, whether taught separately or coeducationally, qualificiations of the instructors, curriculums utilized and methods of presentation, administrators, attitudes toward this instruction and the dating policies of schools. However, we felt there remained a need to

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investigate in more detail what topics are included in the curriculum and the amount of time devoted to the formal instruction of sex education per year. Thus, this present study is an attempt to update, supplement, and complement the former studies.

Other published materials relating to the sex education of hearing impaired children are primarily reports describing specific programs at particular schools (e.g., Miller, 1973) and do little to provide a picture of the overall national situation.

Methodology

A 24-item questionnaire was sent to each of the 112 residential facilities, including residential schools for the deaf (Res/deaf) and residential programs for the multiply handicapped (Res/MH), but excluding postsecondary programs. The April, 1974, Annals was the reference. Responses were received from 99 programs (88%). These responses were then tabulated and reported according to program type and private or public sponsorship.

Table 1. Availability of Sex Education Programs

Type of Facility	Total Number Participating	With Program		Without Program	
		Number	Percent	Number	Percent
All Facilities	99	65	66	34	34
PUBLIC	86	57	66	29	34
Res deaf	62	48	77	14	23
Res MH	24	9	38	15	62
PRIVATE	13	8	62	5	38
Res deaf	8	5	63	3	37
Res MH	5	3	60	2	40

Results

Table 1 provides summary data for the 99 facilities which responded to the survey. As can be seen from this table, the availability of sex education programs ranged from 38% for public res/MH facilities to 77% for public res/deaf facilities. Both types of privately sponsored facilities had availability rates between these two extremes. The 34 facilities which indicated that they had no sex education reported the following reasons for their position: "against the law," "too hot to handle," "fear of lawsuits," "timid administration," "not enough time in the day," and "handle on a necessary basis."

The survey forms themselves were completed by a variety of personnel. The chief administrator was reported as the respondent in 54 facilities (54%), while data for 22 facilities (23%) were reported by support personnel such as teachers, social workers, nurses and psychologists. The position of the respondent was not indicated by 23 facilities (23%).

Summary of Responses

Is sex education provided as a separate course or included in other courses? Separate courses were offered by 60% of all responding programs, while 55% reported that they integrate sex education into other existing courses. Many programs used both methods.

At what academic levels are separate courses offered? For all facilities, 15% offer separate courses at the primary level, 60% offer them at the elementary level, and 82% have such courses at the secondary level. No private or public res/MH facility offers a separate course at the primary level.

In which department is sex education offered? The academic department provides sex education in 54% of all facilities, while physical education is the location in 8% of the facilities. Instruction is provided after school by 39% of the programs, through family living courses, the vocational department, vocational rehabilitation, or home management. Some schools have more than one sponsoring department.

Into what other courses is sex education integrated? Sex education is provided in health courses by 75% of all facilities, in science courses by 42%, and in guidance periods by 28%. Other courses in which sex education is integrated include home economics, family living, nursing, and religion.

Is sex education provided in the dorms? If so, at what levels? Sex education is offered in the dorms by 46% of the public facilities, but only 25% of private facilities. Of those programs which offer sex education in the dorms, 85% make it available at the secondary level, 74% at the elementary level, and 30% at the primary level.

Are sex education classes coeducational? Coeducational classes only are used by 28% of all programs, while separate classes only are provided by 34%. The remaining 38% use both methods of instruction. Students are separated most often during discussions of menstruation, masturbation, sexual anatomy, homosexuality, and sexual intercourse.

How many hours per school year are devoted to sex education? The overall average was 47 hours per school year. One school reported 720 hours, which is the equivalent of about 2/3 of all class time in an academic year. Since this response was apparently meant to make a point about the integration of sex education into all education, it was not included in calculating the average reported. The average varied with

the level of the students, ranging from 13 hours per year at the primary level, to 22 hours per year at the elementary level, to 62 hours per year at the secondary level.

Who are the sex education instructors, and have they been specially trained? The classroom teacher was the sex education instructor 70% of the time. Physical education teachers, nurses, dormitory teachers, guidance counselors, psychologists, ministers, religious teachers, and department supervisors were also utilized in varying degrees. While only 15% of all facilities report that special training is required for sex education instructors, 45% of all instructors were reported to have actually received some special training.

What curriculum materials are used? The Illinois School for the Deaf curriculum, the Ball State University materials and the Follet Family Life Series were the most frequently used at all levels. The SIECUS study guides were also used at the elementary and secondary levels by some programs. A wide variety of other commercial and locally prepared materials are also employed by individual programs.

Table 2. Topics Included in Sex Education Curriculum

Topics Included In Curriculum	All Facil.		Public		Non M-H		M-H		Private		Non M-H		M-H	
	No.	Per.	No.	Per.	No.	Per.	No.	Per.	No.	Per.	No.	Per.	No.	Per.
Marriage	57	88	51	90	43	90	8	89	6	75	4	80	2	67
Childbirth	56	86	51	90	42	88	9	100	5	63	3	60	2	67
Venereal Disease	55	85	50	88	43	90	7	78	5	63	3	60	2	67
Sex. Intercourse	53	82	47	83	39	81	8	89	6	75	4	80	2	67
Premarital Sex	52	80	46	82	39	81	7	78	6	75	4	80	2	67
Masturbation	52	80	47	83	38	79	9	100	5	63	3	60	2	67
Birth Control	48	74	45	79	38	79	7	78	3	38	1	20	2	67
Homosexuality	43	66	39	68	32	67	7	78	4	50	3	60	1	33
Abortion	39	60	37	65	31	65	6	67	2	25	1	20	1	33
Lesbianism	37	57	33	58	27	56	6	67	4	50	2	40	2	67
Divorce	35	52	33	58	26	54	7	78	2	25	1	20	1	33
Rape	34	52	31	54	26	54	5	55	3	38	2	40	1	33
Extramarital Sex	28	43	25	44	19	40	6	67	3	38	2	40	1	33
Bisexuality	21	32	20	35	17	35	3	33	1	13	1	20	--	--
Other[1]	16	25	16	28	11	23	5	56	--	--	--	--	--	--

[1]Other topics included: Menstruation, relationships, dating, singles, genetics, pornography, heredity, and communals.

Which topics are included in the sex education curriculum? Table II shows the topics covered, in descending order of frequency for all programs taken together.

Discussion

While the overall picture presented here is perhaps more favorable than one might have expected, the fact remains that one out of three residential programs offers no sex education at all to its students specifically. As noted in the introduction, however, formal instruction is not the only path by which teaching and learning is accomplished, and one must ask what teaching and learning occurs based on the simple fact that a school chooses pointedly to omit consideration of one very basic and universal part of life.

A related consideration is that 15% of the respondents indicated that sex education classes were scheduled "as needed." While this suggests flexibility on the one hand, it perhaps indicates, on the other hand, a program which is crisis-oriented rather than planned and on-going. Again, the "informal" message which is communicated to students by the very fact that sex education is offered only on a crisis-oriented basis needs to be pondered in its implications.

It is also of little comfort to note the limited availability of sex education at the primary level, despite general agreement on the importance of attitudinal development during these early years of life.

The survey responses indicated that 45% of the sex education instructors had received some special training for this role. Space limitations precluded obtaining information on the nature and extent of

this special training: however, Malfetti (1969) found that only 21% of 250 responding teacher training institutions indicated that they offered one or more courses designed to prepare teachers to teach sex education. Both Malfetti's results and write-in responses to the present survey suggest that the majority of the "special" training reported consisted of summer workshops. It appears that many professional training programs are only beginning to recognize and fulfill their responsibilities in this regard. As an example, two major universities in the Washington, D.C. area are only this year adding human sexuality training to their nursing curricula.

Summary and Conclusion

In short, this survey has examined the characteristics and availability of existing sex education programs in residential schools for deaf children. Comparable information on the day schools and day class programs remains to be developed.

"Write-in" responses on the survey forms provide useful suggestions for future work in this area. A number of respondents requested aid, information, and guidance, saying that they recognized the need for such programs, but were unsure of where and how to begin. Others referred to the lack of qualified staff to teach such programs, or spoke of the need to provide sex education for staff members as well as for students. Some respondents expressed the view that sex education was "not the school's business," or indicated that fear of public reaction, general misunderstanding, and the paucity of trained sex educators have prevented the development of such programs. Suffice it to say, we have only begun to understand and provide adequately for this area of human growth and

development, and that we have a great deal more to do before we can honestly assert that we are providing realistic instruction in human sexuality. Even in dealing with college students who are deaf, we continually confront three ubiquitous obstacles: ignorance, fear and misunderstanding. Deaf people, as do we all, have a right to full, accurate, and understandable information concerning our sexuality.

Postscript

Detailed information on survey responses, safeguarding the confidentiality of the program which supplied the responses, is available upon request from the authors. Our special thanks and appreciation go to Mr. Albert Pimentel, Public Services Program, Gallaudet College, whose financial support and encouragement made this survey possible. Thanks are also due to members of Gallaudet's research staff who assisted with data analysis and the preparation of this report.

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HUMAN SEXUALITY AND THE HANDICAPPED CHILD

Della Fitz-Gerald
Max Fitz-Gerald

Learning about one's sexuality occurs both formally and informally throughout one's life, and many opportunities are normally provided in one's environment. It can be observed that individuals learn about their sexuality in three significant ways: (1) directly (from personal experience), (2) indirectly (from talking or reading about it), and (3) through observation (from listening to and watching others). This is a constant process for individuals of all ages as "the entire realm of human sexuality may be likened to a journey without end -- a constant process of exploration and evaluation."[1]

Sexuality is reflected in the way an individual dresses, speaks, behaves, walks, and feels about himself and others. Thus, our sexuality is at the very core of our personal identity.[2] It has been observed that sex means things other than sexual intercourse . . . "it means all the ways that men and women are different: how they act, how they dress, how they move, how they talk, how they think, how they feel, how they play, what kind of jobs they do, and how their bodies are made."[3] In fact, no other single force influences a person's life as much as membership in one or the other sex.[4]

Currently many researchers and educators are distinguishing between the meaning of sex and sexuality. Sex usually refers to one's genital

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identification or the behaviors in which one engages. On the other hand, sexuality represents a life force, an expression of values, attitudes, beliefs, and identity. Sexuality is something we are rather than something we do. This life force is with us from birth.

A Look at Sexual Development

How does the child develop sexually? The sexual development process can be viewed from a developmental, psychoanalytical, or behavioral approach; however, categorizing these approaches is not our intention. It is important to observe how these approaches can be synthesized. Masters and Johnson have appropriately observed that sexual functioning is a natural biological process, as the male infant has an erection at birth just as the female begins vaginal lubrication several hours after birth.[5] Biologically healthy males and females continue these processes nightly every 80-90 minutes during sleep. Nonetheless cultural influences act upon our sexual functioning, beginning at birth and continuing throughout life.

Some of the most recent research in sexual development has observed the psychohormonal interaction of environment and genetics. Money has noted that a child establishes his or her gender identity (I am male/ I am female) through a process of identification with the same sex and complementation with the opposite sex. The male child is born with a penis just as the female child is born with a vagina; however, significant adults identify behaviors as either male or female. For the male child, things labeled female are coded negative just as things male are labeled negative for the female child. This negative code is learned as what not to do as well as what to expect from the opposite sex.[6] Thus it

may be that the biological reality of maleness and femaleness and the socially transmitted information combine to produce gender identity. Money's research suggests that the child's gender identity is established by the age of two.[6] It also appears that role identity is established early, in that the child can identify male roles and female roles before the first grade. One need only to ask a preschooler what mommies and daddies do, to observe this.

Prepubescent sex play occurs naturally during childhood as the child explores his/her body. Genital masturbation and same sex behavior occurs during early childhood, in the form of games with self and others. By adolescence, many young people have had some sexual contact, exposure to explicit materials, petting experiences, and premarital intercourse. Current statistics indicate one million pregnancies occur annually. Young people are sexual.

By the age of two, groundwork for gender identity, role behaviors, intimacy, and acceptance are being laid. The deeper meaning of acceptance, intimacy, and behaviors occurs by six, while deeper self-awareness, anxieties, emotional and physical development, and relationships evolve with prepubesty and puberty.

During each of these stages, understanding sexuality occurs directly, indirectly, positively or negatively. Often, the home and community will send mixed messages to the young person, creating ambivalence, double standards, lack of information or misinformation. Such a mixed message may be verbal or unspoken. For example, one will learn: "Sex is beautiful/Don't tell my children," or "Sex is dirty/Save it for someone you love." Such information and ambivalence provides the foundation for the development of skills, attitudes and values. Thus,

upon these skills, attitudes, and values the young person acts.

Directly and indirectly, the child asks questions and expresses concerns for his/her sexuality. An informative survey of 5,000 Connecticut students from kindergarten to the twelfth grade provides some insights into these expressed sexual concerns. Even at kindergarten, children question the miracle of "babies in mommy's stomach." By the fifth and sixth grade, questions about puberty, reproduction, menstruation, birth control pills, abnormalities, genetics, and pregnancy abound. The seventh and eighth graders question values, relationships, and why adults haven't talked about sex. The older the student, the more they complain about their lack of sexual information and discussions.[7] The young people in this survey expressed a desire for open, honest communication early.

In this Connecticut survey, the third graders questioned abnormal births. This concern continued to be expressed. Such a concern may reflect an indirect question as to their own "normalcy." Most sex educators and helping professionals encounter the continual concern for both personal "normalcy" and sexual "normalcy." The anxiety for "normalcy" is a natural outgrowth of limited opportunities to express sexual concerns, as well as a societal expectation of normalcy in sexual functioning. Often few efforts are made to discuss this affective area of development yet it relates so personally to the young individuals' self-concept and tolerance towards individuals not like oneself.

The Value for Normalcy

The Connecticut survey clearly indicated that young children and adolescents show concern for abnormal births. It appears that children

learn the value of "normalcy" very early. It can be observed that the "able-bodied" person is unable to understand those that are different, and consequently place a negative value upon the handicapped person. Such attitudes and values are developed and passed on to each generation through adult modeling, both at home and in the community.

As a sociological phenomenon, deviance or stigma concepts denote behaviors or appearances that are perceived as abnormal or that are societally unacceptable. Such concepts have been attached to the individual with a handicap. The term handicap means disadvantage, whereas disability denotes inability to perform because of an impairment. Interestingly, many handicapping conditions connote stigmatization and/or disability. Often society's reaction to a handicapped person is withdrawal, thus producing isolation and disability for the handicapped individual. However, a handicapping condition does not have to denote inability or unacceptance, since the handicapped person is a person. Often, opportunities to socialize or work with a handicapped person facilitate realization of this fact; whereas, isolation perpetuates stigmatization.

Where is the handicapped child today? This fall, the federal government mandated the far-sweeping All Handicapped Child Act. In our country there are seven million children who have been diagnosed as handicapped. This group includes: mental retardation, hard of hearing, deaf, speech impairments, visual impairments, emotional disturbance, orthopedic impairments, heart conditions, tuberculosis, rheumatic fever, nephritis, asthma, sickle cell anemia, hemophilia, epilepsy, lead poisoning, leukemia, and diabetes. With such a far-reaching federal mandate, these children have the right to be educated within their local

public setting.[8] The issues of stigmatization and isolation become realities that must be faced by the community, the professional, and the handicapped child. The handicapped child will become visible.

Environments must be "barrier free" to accommodate the handicapped. Ramps, interpreters for the deaf, and Braille materials are some of the services that will make the handicapped a part of the community. Thus, the community now shares in the responsibility to socialize and educate the handicapped child.

Implications of A Handicap Child in A Family

Often, parents' first contact with a handicapping condition is through their own child. Few opportunities have occurred to educate, prepare, or sensitize the parent to the implications of the handicap. Often, parents experience frustration, guilt and anger over discovery and/or misdiagnosis and diagnosis. Such frustration often occurs with a deaf child. According to one survey, one-third of the parents of deaf children were told by the first physician consulted that their children were not deaf; and 66% had to see four or more physicians before a correct diagnosis was made.[9] Frustrations and guilt occur sooner for the parents of children with more visually obvious handicaps. These negative feelings can be "taken out" on the child. With the deaf child it has been observed:

> Parents understandably become angry and frustrated, sometimes "taking it out" on the child, even though they realize that the child is not to blame (Vernon, 1971).

Many parents often exhaust their energies coping with their own

frustrations, thus leaving little strength to delve into the psychosocial-sexual concerns of their children. It is also true that few parents receive guidance and/or counseling for their own personal growth, especially time spent on helping them to become comfortable with their own sexuality. Attitudinal extremes from overprotectiveness to laissez faire can be observed. As a result, parents' relationships with each other may suffer. One survey of the parents of students attending a leading West Coast school for the deaf indicated that two-thirds were divorced.[10]

Such statistics can be repeated with families of other handicapped children. Gendel has observed that parents of the mentally retarded child may be caring, indifferent, neglectful, abusive or retarded themselves. With other handicaps, such parent-child relationships may evolve. Research has not evolved to explore the implications of these parent child relationships upon psychosexual development. Nonetheless, the parents' feelings and interactional patterns have an effect upon the handicapped child's feelings of self and self-worth.

Sexual Implications for Handicapped Child

When a physical or mental impediment interferes with the sexual learning process, the more natural opportunities for learning about sexuality are limited and often are not available. What are the effects of such a loss on one's psychosexual learning processes?

Although good child sex education evolves from good parent education, it is unreasonable to expect parents of handicapped children to be knowledgeable or accepting of their child's sexuality when they may not be comfortable with their own. Most parents did not receive their sex

education from their own parents, so they have had few, if any, models to guide them. Nonetheless, the family has the initial input into the handicapped child's evolving sexuality. The models of male and female become very important.

The handicapped child will be born a biological male or female. For some handicapped children, the coded maleness and femaleness may or may not occur. Little is known about this coding for the blind, deaf, deaf-blind, or emotionally disturbed. It can be observed that the handicapped child's opportunity to develop sexually may well be hampered by the stigmatization and isolation that often occurs. Most handicapping conditions have historically been interpreted as special and necessitating removal from the mainstream. Many children have been placed in an institution or special school. Such facilities as schools for the deaf and/or blind, institutions for the mentally retarded, emotionally disturbed, and multiply handicapped have evolved as attempts to help the handicapped child. Other medically involved handicaps such as heart disease or orthopedic impairments have necessitated hospitalization for extended periods of time.

Sol Gordon has observed:

> These stereotypic means of serving people with special needs, through institutionalization and isolation, reflect an assumption that people with disabilities have neither the interest nor the ability to interact with the larger society.[12]

Many mentally and/or physically handicapped children are educated in these special facilities. They may leave home by the age of four or five. Surrogate parents in the form of teachers, houseparents, or staff become significant models. Often these staff members are not prepared to

handle the direct and indirect sexual questioning of the handicapped child.

Usually, few opportunities for privacy exist within a residential facility, since adult supervision and dormitory living arrangements exist. Males and females are often separated for most activities. Leisure time for informal opposite sex communication or interaction may be limited or highly structured. Within schools for the deaf:

> Many opportunities for sex education occur naturally in the dorm. Sexual exploration, acting out, and imitation frequently evolve as the children interact. Houseparents often assume one of two roles: that of ostrich or of disciplinarian. In many schools, houseparents are required to supervise students at all times except when the students are in class. Such regulations completely deprive young people of privacy, as social interaction is permitted only in large groups and within restricted environments.[10]

This is not unique to schools for the deaf. Gordon has observed that staff in institutions for the mentally retarded "are often concerned with curbing masturbation, homosexual behavior and heterosexual behavior."

Although statistical data is not readily available on handicapped children in residential settings, there may be a higher percent of same sex exploration. If sexual separation is a reality, then a higher percent of same sex behavior will most likely be a reality. Opportunities for same sex behavior and discouragement of opposite sex behavior become more exaggerated than with the non-institutionalized child.

The non-institutionalized handicapped still experiences social isolation. Fredrick Bidgood has observed:

> As the handicapped child grows, he becomes aware of sexuality in many of the same ways as a "normal" child, through watching television (especially the soap operas), going to movies, reading advertisements oozing sexual overtones, but unlike the non-handicapped child, he is rarely socialized. The child's disabilities do not permit him the freedom from supervision to join in the games and social activities of other children.[13]

Handicapped children living in non-residential settings experiencing social isolation have limited opportunities to discuss and explore their sexuality. The orthopedically impaired child can become physically barred from his world just as the blind child has visual barriers and the hearing-impaired child has oral communication barriers. These social barriers limit the handicapped child's involvement in learning. Other avenues are often sought, for the child is a sexual being with needs and questions. Sexual acting out or sexual withdrawal may occur as extreme responses to the limitations imposed.

Just what are the effects of social isolation and residential life upon the handicapped child? In all honesty, there is a paucity of research regarding the psychosocial implications of institutionalization and isolation. Generally speaking, research tends to indicate that residential life may be less than positive to some respects of psychosocial-sexual development. It has been observed that social isolation and the rate of social interaction are directly related to

role-learning and effective socialization.[14] Therefore, effective socialization becomes more difficult when individuals are isolated from the very system into which they are being socialized.

Does the handicapped individual face greater obstacles regarding gender identity? Ramey, in Intimate Friendships, states that "a boy's concept of maleness and a girl's concept of femaleness is a result of what he or she sees and hears."[15] If this statement has any validity, then it may hold unlimited implications for the deaf, as well as the blind. Is there evidence of confusion of greater identity? What does the greater percent of homosexual behavior in residential settings mean for the handicapped youth? What specific ways do the different handicapping conditions affect sexuality? These are some of the questions and issues that must be better researched and explored by professionals in the perceptive fields.

The Health Professional

The implications for the professional's role in fostering a healthy sexuality for the handicapped becomes complex. The initial step is the awareness of the handicapped child's right to be a sexual person. The deaf, blind, crippled, mentally retarded, and all of the other millions of disabled children are people with sexual needs, yet all handicapped persons share with us a heritage traditionally rooted in avoidance, censorship, and suppression of sexual growth and development. However, this reality is carried even further for the disabled since they are usually societally prejudged either as "not interested" in sex or as "oversexed."

The handicapped person's first hurdle in overcoming these stigmas is

"self-deprogramming," that is, rejecting the idea that one is not potentially sexual or lovable. The second hurdle is "effective militancy," or doing something about these misconceptions.[16] Both tasks require constant efforts on the part of individual handicapped persons and the professionals working with them.

As a society, we are really just beginning to recognize that the physically and/or mentally handicapped are sexual beings, with the same desires, curiosities, hopes, and expectations as any other group of people. Some disabled persons have begun demanding their sexual rights, privileges, and opportunities.

As health professionals, we face the challenge and responsibility of reevaluating our own attitudes toward the handicapped in order to better work with family and community. Furthermore, we share in the responsibility of facilitating more open and accepting attitudes in our settings. Some may be called upon to work directly with the young handicapped person and the family. Understanding the child, one will begin to understand oneself. Thus, the task is great, but so is the need.

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PARENTS: A CHILD'S FIRST SEX EDUCATOR

Max Fitz-Gerald

When does a child's instruction in sexuality begin? Many would perhaps say that this aspect of the child's education begins during adolescence. Actually, instruction in sexuality begins at birth and continues until death. Learning about our sexuality may be likened to a journey without end -- a journey that each of us is taking. None of us have arrived. We only have a few more years' experience than children.

Learning about one's sexuality occurs both formally and informally throughout one's life, and many opportunities are normally provided in one's environment. It can be observed that individuals learn about their sexuality in three significant ways: (1) directly (from personal experience), (2) indirectly (from talking or reading about it), and (3) through observation (from listening to and watching others). This is a constant process of exploration and evaluation for individuals of all ages.

Sexuality is reflected in the way an individual dresses, speaks, behaves, walks, and feels about himself and others. Thus, our sexuality is at the very core of our personal identity. It has been observed that sex means things other than sexual intercourse . . . "it means all the ways that men and women are different: how they act, how they dress, how they move, how they talk, how they think, how they feel, how they play,

what kind of jobs they do, and how their bodies are made."* In fact, no other single force influences a person's life as much as membership in one or the other sex.

Currently many researchers and educators are distinguishing between the meaning of sex and sexuality. Sex usually refers to one's genital identification or the behaviors in which one engages. On the other hand, sexuality represents a life force, an expression of values, attitudes, beliefs, and identity. Sexuality is something we are rather than something we do.

The Pre-College Programs recognizes the fact that because instruction in sexuality begins at birth and is a life-long process, parents are a child's first and most important sex educator. Schools cannot replace the parents in this role. Schools can never be more than an adjunct to what children learn about sex at home. It is with this premise in mind that the Pre-College Programs have established a partnership between parents, the community, and the school. This is a partnership which is founded upon the belief that by working together and supporting one another, each is better able to provide a safe, nurturing environment which enhances each child's ability to make wise, responsible decisions about their sexuality.

Since many of our parents did not really tell us the facts of life, we often do not know how to go about telling our own children. This was reflected by our Pre-College parents through the telephone and written surveys conducted by the Kendall Demonstration Elementary School (KDES)

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*Eric W. Johnson. Sex: Telling It Straight. Philadelphia: J.B. Lippincott, 1970.

and Model Secondary School for the Deaf (MSSD) Sex Education Committees. Parents expressed their support of education for sexuality programs in the schools, but also requested support and assistance for them to carry out their role.

Thus, the first of a series of parent workshops was planned and sponsored by the Kendall Home School Organization and the Kendall Sex Education Committee on Saturday, October 21, 1978. Approximately fifty parents, teachers, and community members participated in this first workshop. The goal for the day was to provide participants with a general understanding of what sex, sexuality, and education for sexuality means; how one learns about their sexuality; and provide an open forum for sharing concerns and learning techniques for creating an "askable" environment in the home.

The morning was structured to provide parents and teachers with children in either the elementary, junior high, or senior high an opportunity to meet in three small groups and discuss and list all the ways they could think of that their child expresses his or her sexuality. The three groups then met together in one large group and shared their list. What unfolded was a developmental chart of a child's sexual growth and development.

In the afternoon, a panel of six parents responded to questions which had been written by participants earlier that morning. The panel's responses were not intended to be the one and only way to respond to questions being raised. Their responses did provide an idea of how another parent had or might respond. This approach generated excellent discussion from the entire group.

The evaluations indicated a desire for future workshops which would focus upon a better understanding of how to become an "askable" parent. Therefore, additional workshops are being planned by both KDES and MSSD parent organizations.

Parents cannot expect to convey, via their attitudes, any meaningful code of sexual morality to their children until they:

1. face the issue openly;
2. examine objectively current scientific knowledge of human sexuality;
3. look at their own sexual beliefs and behaviors;
4. become consciously aware of the values they wish to convey to their children;
5. attempt to integrate contemporary scientific knowledge into their own value system; and
6. attempt to understand how sexual information, attitudes, and values are conveyed to children from infancy on.

The Pre-College Programs recognizes that these are difficult tasks to accomplish alone. However, by working together as a team, the likelihood of helping each child develop a healthy sexuality is greatly increased.